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Dear Physician,

One of your patients has contacted our organization expressing interest in joining our program to participant in mounted equine programming (occupational therapy, camp, therapeutic riding

Enclosed is a Physician Referral Form and a list of contraindications and precautions for Therapeutic Riding.

Please review the list of contraindications and precautions, and consider the ones that may be applicable for your patient. As well, please review the list of conditions that require cervical spine and/or flexion-extension X-Ray. If an X-Ray is indicated, please attach a copy of the results of the X-Ray report to this referral. Where possible, please be specific with your comments as they will help our staff decide on this patient's suitability for riding, and will help provide a better-quality individualized program for the patient.

Horseback riding is considered a risk sport; despite our best efforts, a risk of a fall or other injury is always present. Our Therapeutic Riding Instructors are trained to ensure all Canadian Therapeutic Riding Association (CanTRA) precautions & safety standards are followed, as well as ensuring that volunteer leaders and side walkers are attentive and do everything in their power to ensure the rider's safety.

Please feel free to contact us with any questions or concerns.

Thank you for your cooperation.

Melissa Horvath

Executive Director

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Guidelines for Physicians/ Therapists

CONTRAINDICATIONS AND PRECAUTIONS FOR THERAPEUTIC RIDING

The following conditions may represent precautions or contraindications to therapeutic horseback riding if present in potential participants. Therefore, when completing the physician's referral, please note whether these conditions are present and to what degree.

ABSOLUTE CONTRAINDICATIONS

ORTHOPAEDIC

- Acute arthritis
- Acute herniated disc or prolapsed disc
- Atlanto-axial instabilities
- Coax arthrosis (degeneration of hip joint)
- Structural cranial deficits
- Osteogenesis imperfecta
- Pathological fractures
- Spondylolisthesis
- Structural scoliosis >30 degrees, excessive kyphosis or lordosis or hemivertebra
- Spinal stenosis
- Hip subluxation, dislocation or dysplasia (one hip)

NEUROLOGICAL

- CVA secondary to unclipped aneurysm or angioma
- Paralysis due to spinal cord injury above T6 (adult)
- Spina bifida associations – Chiari II malformations, hydromyelia, tethered cord
- Uncontrolled seizures within the last 6 months

MEDICAL

- Obesity or >170 lbs

RELATIVE CONTRAINDICATIONS AND PRECAUTIONS

OTHER

- Age under 2 years old
- Any condition that the instructor, therapist, physician or program does not feel comfortable accepting into the program

ORTHOPAEDIC

- Arthrogyrosis
- Heterotopic ossification
- Hip subluxation, dislocation or dysplasia
- Osteoporosis
- Spinal fusion/fixation, Harrington Rod (within 2 years of surgery)
- Spinal instabilities/abnormalities
- Spinal orthoses

NEUROLOGICAL

- Amyotrophic Lateral Sclerosis
- Fibromyalgia
- Gullian Barre Syndrome
- Exacerbation of Multiple Sclerosis
- Post Polio Syndrome
- Hydrocephalic shunt

MEDICAL / PSYCHOSOCIAL

- Abusive or disruptive behaviour
- Cancer
- Hemophilia
- History of skin breakdown or skin grafts
- Abnormal fatigue
- Incontinence (must wear protection)
- Peripheral vascular disease
- Sensory deficits
- Serious heart condition or hypertension
- Significant allergies
- Surgery within the last three months
- Uncontrolled diabetes
- Indwelling catheter
- Substance abuse
- Anticoagulants (bleeding risk)

FLEXION/EXTENSION X-RAY REQUIRED FOR ATRAUMATIC FACTORS THAT MAY BE ASSOCIATED WITH AN UNSTABLE UPPER CERVICAL SPINE

- Down syndrome
- Os odontoideum
- Athetoid cerebral palsy
- Rheumatoid arthritis of cervical vertebrae
- Congenital torticollis
- Sprengel's deformity
- Ankylosing spondylitis
- Congenital atlanto-occipital instability
- Klippel-Feil syndrome
- Chiari malformation with condylar hyperplasia
- Fusion of C2-C3
- Lateral mass degeneration change at C1-C2
- Systemic lupus
- Morquio disease
- Non-rheumatoid cranial settling
- Subluxation of upper cervical vertebrae due to tumours or infection
- Idiopathic laxity of the ligaments
- Grisel's syndrome
- Lesch-Nyhan syndrome
- Marshall-Smith syndrome
- Diffuse idiopathic hyperostosis
- Congenital chondrodysplasia

***** Physician Referral Form on next page*****

TO THE PHYSICIAN AND / OR PHYSIOTHERAPIST, AS APPROPRIATE

Diagnosis:

Recent Injuries (within the last 5 years):

Name & date of significant operations:

Medications:

Relevant medication side effects:

Epileptic: () Last seizure: Frequency of seizures:

Diabetic () Fainting () Allergies ()

If yes, to what?

Circulatory impairments () Incontinence - bladder () Incontinence – bowel ()

Visual impairments () Hip subluxation or dislocation (left, right, or both) ()

Behavioural or psychological concerns () Speech impairments ()

Auditory impairments ()

Specify (e.g if visually impaired, classification B1, B2 etc):

Coordination: Normal () Specific deficit:

Areas of concern (please check):

Flexibility/Range of Motion () Strength () Mobility () Physical Fitness ()

Body/Spatial Awareness () Sensory behaviour () Motor Planning ()

Communication () Other (please specify):

Gross Motor Skills Good () Fair () Poor () Specify:
Fine Motor Skills Good () Fair () Poor () Specify:
Balance (Sitting) Good () Fair () Poor () Specify:
Balance (Standing) Good () Fair () Poor () Specify:
Balance (Walking) Good () Fair () Poor () Specify:

Tone in upper extremities:

Tone in lower extremities:

Tone in trunk:

Spasticity () If yes, explain:

Ambulatory: Yes () No () If no, explain (e.g wheelchair, walker, braces, crutches, etc.)

Are there any exercises that you would recommend for the applicant while riding? Please describe.

Are there any exercises this participant should not be doing? Please describe.

Are there any known communicable diseases? Please specify.

The undersigned hereby acknowledges that _____ is medically able to participate in the Horse-Riding Program offered by TEAD Therapeutic Riding Centre. I concur with the referral of the patient to an Occupational Therapist for evaluation of his/her physical abilities and/or limitations, as deemed necessary.

Name of Applicant's Doctor:

Phone:

Address:

Physician Signature:

Parent/Guardian/Applicant:

Date:

NOTE: TEAD Therapeutic Riding Centre collects information in alignment with federal privacy legislation. The Personal Information Protection and Electronic Documents Act (2000) guides our collection, storage and use of all personal information. Any information provided may be used to decide on this applicant's suitability for riding or other programming and help provide a better-quality individualized program for the participant.

Atlantoaxial Dislocation Examination

Due to the nature of mounted equine programs, persons diagnosed with Down Syndrome cannot be accepted for riding instruction without proof of a negative diagnostic x-ray for atlanto-axial instability. This form must be accompanied by a signed and dated statement from a medical doctor giving the date and result of the diagnostic x-ray. This form must be updated every 2 years. **Please attach a copy of the x-ray results.*

Date:

This is to certify that _____, who has a diagnosis of Down Syndrome, has requested the x-rays taken (full extension and flexion of the neck) to determine a pathological displacement of C1 or C2.

Date of x-ray:

Results:

Positive

Negative

Medical doctor's name (print):

Address:

City:

Postal Code:

Telephone:

Medical doctor's signature:

Medical doctor's stamp:

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